Washington State Department of Health
Washington State Board of Pharmacy
PO Box 1099
Olympia, WA 98504-1099
360.236.4700

Pharmacy Intern Application Packet for US Students

Contents:

Important Social Security Number Information:

Social Security Number: You are required by state and federal law to provide a social security number with your application.

If you do not have a social security number at the time you send in this application, please contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Return Completed Applications with Payment to:

Department of Health,
PO Box 1099,
Olympia, WA 98507-1099

Send additional documents to:

Customer Service Center
P.O. Box 47865
Olympia, WA 98504-7865
360.236.4700

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General Instructions Checklist

☐ **#1: Demographic Information:**

Social Security Number: You are required by state and federal law to provide a social security number with your application.

If you do not have a social security number at the time you send in this application, please contact the Customer Service Center at 360.236.4700 for more information.

Name: Please list your current name with middle initial.

Residential Address: Please identify the address to which you wish all correspondence, including your credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

Telephone Number: Enter current number where you may be reached during normal business hours.

☐ **#2: Personal Data Questions:**

All applicants for certification are required to answer the same personal data questions. These are narrowly focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation and the documentation listed in the note following the question. If you do not provide the documents, your application is incomplete an your application will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can obtain copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- For question 5, you must answer yes if you were convicted as either a juvenile or adult. The question includes misdemeanors, gross misdemeanors and felonies. "Another jurisdiction" means any other country, state, federal territory, military or establishment.

☐ **#3: Previous Credentialing:**

Check Yes or No if you are currently certified as a Pharmacy Technician in Washington State? Internship hours may not be earned as a Technician.

☐ **#4: Applicant's Attestation:**

You must sign and date this for us to process the application. Read thoroughly to ensure you understand the provisions in this section.

☐ **#5: Applicant's Photograph:**

Attach a current photograph in the box provided or attach to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up, and a front view. Your application will not be processed without a current photograph.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

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Pharmacy Intern Application Instructions
US Students

The following instructions will assist you in completing the application process for registration as a pharmacy intern in Washington State.

To register as an intern, you must be enrolled in a United States pharmacy school or be a graduate of a pharmacy school from a foreign university. Information and applications are also available at our **Web site**.

Once your application has been approved, a pharmacy intern registration is issued. The registration will expire on your next birthday. This registration is renewed annually.

If you are attending the University of Washington or Washington State University you may register as an intern once you are accepted into the pharmacy program. Proof of enrollment must be received by the department before your intern registration can be issued. You may work as an intern once your registration is issued. Only hours accumulated after you have completed your first quarter or semester of pharmacy school will count towards the 1500 hours required.

To register as an intern, the pharmacy board office must receive:

1. Completed application for pharmacy intern registration and the nonrefundable fee.

2. Proof of acceptance sent directly from the pharmacy school.

If you have questions, please contact the customer service center at 360.236.4700.

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Checklist for US Graduates

Name _____

Address _____

City _____ State _____ Zip Code _____

Dates indicate when we received the following items. The absence of a date indicates that we have not received the item.

Items required before intern registration:

_____ State intern application with the nonrefundable application fee

_____ Letter from accredited pharmacy school verifying admittance

Items required before taking NAPLEX and MPJE:

_____ State pharmacist application with the nonrefundable fee.

_____ Letter of recommendation

_____ Copy of your birth certificate or passport

_____ Official transcript sent directly from your pharmacy school

_____ Certification of 700 intern hours, we have received _____

Required before pharmacist licensure:

_____ Preceptor evaluation

_____ Intern site evaluation report

_____ Certification of a total of 1500 intern hours, we have received _____

_____ 7 hours of AIDS education

_____ NAPLEX Score, on _____ you received a score of _____

_____ MPJE Score, on you received a score of

License # _____ Issued _____ Expired _____

Please send in with your application.

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Background Check Stamp Here

Date Stamp Here

Revenue: 1A 026201000 00787

Pharmacy Intern Registration Application US Student

Please type or print clearly—It is the responsibility of the applicant to submit, or request to have submitted, all required supporting documents. Failure to do so could result in a delay in processing your application. Make sure you have read and understand the instructions.

1. Demographic Information

Social Security Number (**If you do not have a social security number, see instructions**)

— —

Name ☐ Mr. ☐ Ms. First Middle Last

Birth date (mm/dd/yyyy)

Place of Birth: City | State | Country

Address

City | State | Zip | County

Country

Mailing address if different from above

City | State | Zip | County

Country

Phone ( ) | Fax ( ) | Cell ( )

Email Address:

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

Name of pharmacy school_____

Expected graduation date_____ Date attendance in pharmacy classes began_____

For Office Use Only

Issuance Date _____License #_____

Validation_____Date Received_____

2. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach an explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

   Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile, in Washington or another state or jurisdiction? ☐ ☐

   Note: If you answered yes, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and your application will not be considered.

   To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

YES NO

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
   b. Diverted controlled substances or legend drugs? ☐ ☐
   c. Violated any drug law? ☐ ☐
   d. Prescribed controlled substances for yourself? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐

3. Previous Licensure

Are you currently certified as a pharmacy technician in Washington State? ☐ Yes ☐ No

Internship hours may not be earned as a technician.

4. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state of
(print applicant name clearly)
Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____at _____ (city, state)

by:_____
Signature of Applicant

5. Applicant's Photograph

Photo Here

Attach Current Photograph Here.
Indicate Date Taken and Sign in Ink Across Bottom of the Photo.NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

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Intern Self-Evaluation

This form does not need to be sent to the Pharmacy Board Office.

Intern name		Year in school ☐ 1 ☐ 2 ☐ 3 ☐ 4
School street address		Telephone ( )
City	State	Zip
Summer street address		Telephone ( )
City	State	Zip
Emergency contact		Telephone ( )

I. Internship Experience

Preceptor	Location	Dates	Total Hours

II. Background

Preferred practice setting upon graduation
Professional organization membership
Offices held
Skills and experiences hoped to be gained from this internship

III. Evaluation of Experience (Check the appropriate box; other experience may be added)				
Area of study	None	Minimal	Moderate	Extensive
1. Dispensing				
2. Compounding				
3. OTC medication counseling				
4. OTC medication prescribing				
5. Patient interviewing				
6. Patient counseling				
7. Physician contact (personal)				
8. Physician contact (telephone)				
9. Use/preparation of patient profiles				
10. Review of patient medical charts				
11. Provision of drug information				
12. Medical/surgical devices				
13. Ordering and receipt of stock				
14. Controlled substance control				
15. IV admixture				
16. Pharmacy computer system				
17. Patient assessment				
18. Patient drug therapy monitoring				
19. Personnel management				
20. Pharmacy and medical terminology				
21. Triaging problems				
22. Pharmacy/patient record documentation				
23.				
24.				
25.				
26.				
27.				
28.				

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Intern Site Evaluation Report

NOTE: This form must be submitted to the board of pharmacy within 30 days of completion of an internship experience. No internship hours will be accepted without this evaluation report pursuant to **WAC 246-858-050**(1). If the internship experience exceeds twelve (12) months, it is recommended that this form be submitted annually.

Name of Intern
Name of preceptor
Name of internship site
Intern evaluation of preceptor:
Intern evaluation of internship program at this site:

Signature of intern _____ Date _____

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Internship Site and Preceptor Notification

NOTE: This form must be submitted from each preceptor **before** you begin your internship experience.

Name of intern _____

Street address _____

City _____ State _____ Zip _____

Intern registration number _____

Date intern hours will start to accrue _____

Internship site _____

Street address _____

City _____ State _____ Zip _____

Name of preceptor _____

Pharmacist license number _____

_____ _____

Signature of intern Date

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Preceptor Evaluation & Certification of Experience

This form must be submitted to the Board of Pharmacy at the completion of the internship experience. If the internship experience exceeds twelve (12) months, it is recommended that this form be filed annually.

Name of Intern	Year In school ☐1 ☐2 ☐3 ☐4
Intern street address	
City State	Zip
Name of preceptor	
Name of internship site	
Street address	
City	State Zip

Preceptor Evaluation of Intern

Briefly describe the type of professional experience received under your supervision. Comment on the intern's communication skills, accuracy, professional attitude, dispensing skills, ability to evaluate and monitor therapy, and knowledge of pharmacy management. Also, pursuant to WAC 246-858-070(3), provide your assessment of the intern's ability to practice pharmacy at this stage of his or her internship. Attach an additional sheet(s) if needed.

Signature of Preceptor

Date

For The Two-Week Period of			For The Two-Week Period of		
From (Sunday)	To (Saturday)	Hours	From (Sunday)	To (Saturday)	Hours
			Total Internship Hours		

Note: Internship hours will not be accepted after the signature date.

Preceptor Certification of Experience

I, ______________________ certify that I am a pharmacist licensed in the State of ______________________ and the above named intern practiced pharmacy under my supervision at ______________________ pharmacy, or under a special internship program. I certify that the intern has completed goals set forth in the Washington State Board of Pharmacy

Experiential Training Manual, the hours here recorded are correct, and to the best of my knowledge, the experience gained by the intern has been predominantly related to the practice of pharmacy as required by law.

______________________	______________	______________
Preceptor's Signature	Date	License Number

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Health Professions Reference Numbers and Links

RCW Links

UDA RCW 18.30 ..... Uniform Disciplinary Act

APA RCW 34.05 ..... Administrative Procedure Act

WAC 246-12 ..... Administrative procedures and requirements

AIDS Courses

Health Impact ..... 1.800.783.2437 ***or*** 206.284.3865

W.F. Professional 1.800.323.4305

AIDS Resources 206.784.5655

Red Cross offers AIDS classes.
You can also contact your local health department.

On-Line

Aids Training ..... Reference Page

Pharmacy Board ..... Web Site

Required Hours of Training

Pharmacist ..... 7 hours

Technician ..... 4 hours

Assistant ..... 4 hours